

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04513

4567

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>18 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>				d. STREET ADDRESS <u>Middletown 10 x 22</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>E. Walter Beachley</u>				4. DATE OF DEATH Month Day Year <u>4 19 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/10/1871</u>	
9. AGE (In years last birthday) yrs. <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store owner</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>grocery store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ezra Beachley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Floyd Main, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Hemiplegia)</u> <u>33/x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension - Arterio sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH. <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Middletown</u>				20g. (County) <u>Middle</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Nov</u> , 1956, to <u>April 19</u> , 1957, that I last saw the deceased alive on <u>April 18</u> , 1957, and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. J. Elmer Harn</u>				ADDRESS (Street, city or town, state) <u>Middletown</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harn</u>				DATE SIGNED <u>4-19-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/21/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Apr. 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Best</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5 1922		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE		SUICIDE		MOBILE, ALABAMA		APR 4 1968	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAMES EARL RAY		LUCILLE RAY		LABORER		LABORER		JAN 1 1900		JAN 1 1900	

SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE	
JAMES EARL RAY		LUCILLE RAY		JAMES EARL RAY		LUCILLE RAY		JAMES EARL RAY		LUCILLE RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	

BUREAU V. E.

APR 23 1957

RECEIVED

4514

CERTIFICATE OF DEATH

04514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 52 Harmons Ave.,				e. STREET ADDRESS 52 Harmons Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last Grace May Benedict				4. DATE OF DEATH Month Day Year 4 3 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Kelmer				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Harvey S. Benedict Jr.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/2/57 , 19 57 , to 4/3/57 , 19 57 , that I last saw the deceased alive on 4/3/57 , 19 57 , and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/5/57							
ACTUAL SIGNATURE W. E. Young M.D.				WILLIAM E. YOUNG M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-6-57		22c. NAME OF CEMETERY OR CREMATORY XXXX Rose Hill		22d. LOCATION (City, town, or county) (State) Mt. Alto Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 8, 1957	
				24b. REGISTRAR'S SIGNATURE Robert R. Brown			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
HARVEY A. BENEDICT JR.		Male		32	
Date of Death		Place of Death		Cause of Death	
April 11, 1957		Home		Myocardial Infarction	
Time of Death		Occupation		Manner of Death	
11:00 PM		None		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Informant	
April 12, 1957		Bathore, Mo.		[Signature]	

RECEIVED
APR 10 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04515					
Item 2 Film 215 5-2-57 et										302					
Items 18-20 Film 215 5-14-57 as										Reg. Dist. No.					
4515										302					
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY Washington					MARYLAND					a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Hagerstown Md.					4 days					03 Boonsboro Md. Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Washington County Hospital					218 N. Patomac Street					Fahner Memorial Home					
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH					
First Anna Middle Letha Last Bomberger										Month April Day 24 Year 19 57					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 3 1869		87 yrs.		6 Months		20 Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife				Home				Williamsport Md.				U.S.A.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
Emmanuel Bomberger						Martha Byers									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address									
No				None		Mr. Louis Bomberger David West Va.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis										8 yrs.					
450.0 DUE TO										3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) II Fractured hip -															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
902.7															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
					Was confused and got out of bed without assistance										
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)						
Hour a. 11 April 23, 57					While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		Fahner-Keedy Home Boonsboro		Wash. Md.						
21. I certify that I attended the deceased from April 20, 1957, to April 24, 1957, that I last saw the deceased alive on April 23, 1957, and that death occurred at 7:26 PM, from the causes and on the date stated above.															
ADDRESS (Street, city or town, state)															
Boonsboro															
DATE SIGNED 4/24/57															
ACTUAL SIGNATURE G. W. LeVan M.D.															
PHYSICIAN'S NAME (Type) G. W. LeVan Ind.															
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)						
Burial			April 26-57			Riverview Cemetery			Williamsport Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS															
Charles A. Leaf Williamsport, Md.															
24a. REG'D BY REGISTRAR						24b. REGISTRAR'S SIGNATURE									
Apr. 26, 1957						L. H. Bowers									

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04516

Reg. Dist. No. 302

4516

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 51 Harmen Alley				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Betty Middle Jane Last Breadus				4. DATE OF DEATH Month 4 Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 29 1933	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family	
11. BIRTHPLACE (State or foreign country) Harrisonburg, Va.				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Sayler Smith				14. MOTHER'S MAIDEN NAME Mildred Toliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-30-9656		17. INFORMANT Address Hagerstown Md. Mrs Mildred Smith 123 W Bethel St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gun shot Wound Head DUE TO 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) instant DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Enter Face blown off by shot gun					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6:20 p. m. 4-17 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. J. W. Datto Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. F. W. Datto Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-1957		22c. NAME OF CEMETERY OR CREMATORY New Town Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md				24a. REC'D BY REGISTRAR Apr 22 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 24 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04517

Reg. Dist. No. 302

4517

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. c. LENGTH OF STAY IN 1b 13 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 51 Harmon Alley				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland d. STREET ADDRESS 51 Harmon Alley e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carl Franklin Broadus First Middle Last 4. DATE OF DEATH 4 17 1957 Month Day Year				5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 1 1923 9. AGE (In years last birthday) 34 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Car Washer 11. BIRTHPLACE (State or foreign country) Luray, Va. 12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Casper Broadus 14. MOTHER'S MAIDEN NAME Virginia Sire				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War II 16. SOCIAL SECURITY NO. 578-24-1428 17. INFORMANT John Broadus Address Hagerstown, Md. 673 Forest Drive.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gun shot wound of head DUE TO (b) gun shot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) gun shot wound of head DUE TO (d) gun shot wound of head DUE TO (e) gun shot wound of head PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gun shot wound of head INTERVAL BETWEEN ONSET AND DEATH instant							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Entire top of head blown off by shot gun			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4:17 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Hagerstown Washington Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. E. W. Dittman EXAMINER'S NAME (Type) Dr. E. W. Dittman				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-21-1957				22c. NAME OF CEMETERY OR CREMATORY Family Cemetery 22d. LOCATION (City, town, or county) (State) Luray Va.			
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson ADDRESS J. Hagerstown Md				24a. REC'D BY REGISTRAR Apr. 22, 1957 24b. REGISTRAR'S SIGNATURE Wesley H. Bowers			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
Occupation		Cause of Death		Manner of Death		Medical History		Post-mortem Examination		Remarks	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Witness	

BUREAU V. S.

APR 24 1957

RECEIVED

04518

4568

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.				c. LENGTH OF STAY IN 1b 53 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 N. Conococheague Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Abraham Last Buharp				4. DATE OF DEATH Month April Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 10 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baler Operator		10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Buharp				14. MOTHER'S MAIDEN NAME Betty Knable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-01-9968		17. INFORMANT N. Conococheague St # 209 Mrs. Irene Abraham Buharp Williamsport MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVIEW BETWEEN ONSET AND DEATH May	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/27/57 to 4/30/57 , that I last saw the deceased alive on 4/27/57 , 19 57 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport Md. DATE SIGNED 4/30/57							
ACTUAL SIGNATURE Ralph Young				M.D. Williamsport Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1-57		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Reaf				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR May 1-1957	
				24b. REGISTRAR'S SIGNATURE E Lee McElroy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF RETURN

DATE OF REENTRY

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

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BUREAU V. 1

MAY 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Dr E.W.Ditto Jr

04519
302

4518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 West Franklin St		d. STREET ADDRESS 1 20 West Franklin St					
3. NAME OF DECEASED (Type or print) FRANK		First NEWTON		Middle BYWATERS		4. DATE OF DEATH Month April Day 16 Year 1957	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Home Construction Corp		10b. KIND OF BUSINESS OR INDUSTRY Luray Va.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Bywater		14. MOTHER'S MAIDEN NAME Rebecca Gouchenour					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW # 1 212-03-1398		17. INFORMANT Address Mrs Lydia Bywaters 20 W. Franklin St Hagerstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Esophagus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 62w					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-38 , 19 38 , to 4-16 , 19 57 , that I last saw the deceased alive on 4-13-57 , 19 57 , and that death occurred at PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. W. Ditto		M.D. Hagerstown Md		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 4/18/57	
PHYSICIAN'S NAME (Type) E. W. Ditto		M.D. Hagerstown Md		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 4/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Apr. 20, 1957		24b. REGISTRAR'S SIGNATURE W. H. Powers	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is faint and mostly illegible.

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04520

Reg. Dist. No. 302

4519

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Convalescent Home</u>				d. STREET ADDRESS <u>800 Washington Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>BARTON</u> Middle <u>CARLISLE</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 16, 1867</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Petersville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert B. Carlisle</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Mrs. Grace C. Stout Stout Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>indetermin-ate</u> <u>indetermin-ate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>March 24</u> , 1957, to <u>April 22</u> , 1957, that I last saw the deceased alive on <u>April 16</u> , 1957, and that death occurred at <u>11:00 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts. Bldg. 4-24-57</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>W. T. Layman, M.D.</u>		M.D. <u>100 Professional Arts. Bldg. 4-24-57</u>					
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Hagerstown</u> <u>Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/25/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Penner</u>		ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 22, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4520

CERTIFICATE OF DEATH

Reg. Dist. No.

04521
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 62 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Summit Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs. Hannah Mc Coy Carson				4. DATE OF DEATH April 16 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11 1873	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months 10 Days 4 Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Williamsport Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Walter B. Mc Coy		14. MOTHER'S MAIDEN NAME Clara Ardinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J. Howard Rohrer Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Arterio-sclerotic Cardiovascular disease with myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15 19 50, to Apr 16 19 57, that I last saw the deceased alive on 15 Apr 19 57, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				DATE SIGNED 17 Apr 57			
PHYSICIAN'S NAME (Type) F. F. Lusby				ADDRESS (Street, city or town, state) 2307 N. Roman M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 1

APR 22 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 300

4562

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.				c. LENGTH OF STAY IN 1b 17 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. Antietam Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Agnes Last Clapp				4. DATE OF DEATH Month April Day 12 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1898 Aug. 17 1892	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 7 Days 25 Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Room Clerk		11. BIRTHPLACE (State or foreign country) Dargen Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John W. Echelberger		14. MOTHER'S MAIDEN NAME Margaret Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2397		17. INFORMANT Mrs. J. G. Malone Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infiltrating carcinoma of the urethra and 181X DUE TO bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sep. 1 , 19 56 , to 4/12/57 , 19 , that I last saw the deceased alive on 4/12/57 , 19 , and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 4/15/57							
ACTUAL SIGNATURE Walter H. Shealy M.D.							
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.				24a. REC'D BY REGISTRAR DATE 4/15/57		24b. REGISTRAR'S SIGNATURE E. G. Boyer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04523

4570 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wash. Co.		MARYLAND		STATE W. Va.		COUNTY Berkeley	
CITY OR TOWN San Mar		LENGTH OF STAY (in this place) 5 MONTHS		CITY OR TOWN Martinsburg		85x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fahrney Keedy Memorial Home				STREET ADDRESS 410 West King Street			
3. NAME OF DECEASED (Type or Print) Mary Susan Clendening				4. DATE OF DEATH April 6 1957			
5. SEX Female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single		8. DATE OF BIRTH 12 March 1884	
				9. AGE last birthday 73 yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Daniel Wright				14. MOTHER'S MAIDEN NAME Margaret Shoemaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Mrs. Charles Kantner 115 N. Alabama Ave., Mtbg. W. Va.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cardiovascular Collapse				INTERVAL BETWEEN ONSET AND DEATH mm.			
ANTECEDENT CAUSE(S) DUE TO Diseases or conditions, if any, giving rise to the above cause stating UNDERLYING CAUSE LAST, DUE TO (B) Cerebral vas. accident				hrs.			
				mins.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) arteriosclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work <input type="checkbox"/> Not white el work <input type="checkbox"/>		21e. INJURY OCCURRED White el work <input type="checkbox"/> Not white el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-6-57, 1957, to 4-6-57, 1957, that I last saw the deceased alive on 4-6-57, 1957, and that death occurred at 7 P.M., from the causes and on the date stated above.							
SIGNATURE Louis S. S. S.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9 Apr. 1957		NAME OF CEMETERY OR CREMATORY Middleway, W. Va.		LOCATION (City, town, or county) Middleway, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE John H. Baird		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Boorusino md	
DATE 4-9-57							

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text]

2. SEX: [Faint text]

3. AGE: [Faint text]

4. DATE OF BIRTH: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. OCCUPATION: [Faint text]

7. CAUSE OF DEATH: [Faint text]

8. PLACE OF DEATH: [Faint text]

9. TIME OF DEATH: [Faint text]

10. SIGNATURE OF PHYSICIAN: [Faint text]

11. SIGNATURE OF REGISTRAR: [Faint text]

12. SIGNATURE OF WITNESS: [Faint text]

13. SIGNATURE OF DECEASED: [Faint text]

14. SIGNATURE OF NEXT OF KIN: [Faint text]

15. SIGNATURE OF CLERK: [Faint text]

16. SIGNATURE OF CHURCH CLERK: [Faint text]

17. SIGNATURE OF BURIAL CLERK: [Faint text]

18. SIGNATURE OF INTERMENT CLERK: [Faint text]

19. SIGNATURE OF FUNERAL HOME: [Faint text]

20. SIGNATURE OF CEMETERY: [Faint text]

21. SIGNATURE OF BURIAL SOCIETY: [Faint text]

22. SIGNATURE OF OTHER: [Faint text]

23. SIGNATURE OF DECEASED: [Faint text]

24. SIGNATURE OF NEXT OF KIN: [Faint text]

25. SIGNATURE OF CLERK: [Faint text]

26. SIGNATURE OF CHURCH CLERK: [Faint text]

27. SIGNATURE OF BURIAL CLERK: [Faint text]

28. SIGNATURE OF INTERMENT CLERK: [Faint text]

29. SIGNATURE OF FUNERAL HOME: [Faint text]

30. SIGNATURE OF CEMETERY: [Faint text]

BUREAU V. 3

APR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4571

CERTIFICATE OF DEATH

Reg. Dist. No.

04524
304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. LENGTH OF STAY IN 1b <u>40 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Hancock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Brent Street</u>				d. STREET ADDRESS <u>27 Brent Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Irene</u> Last <u>Clingerman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 57</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/15/1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Michael M. Boor</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Divelbliss</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-24-5272</u>		17. INFORMANT <u>Emory C. Clingerman Hancock, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/20/57</u> , 19 <u>57</u> , to <u>4/23/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/23/57</u> , 19 <u>57</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>John Wilson</u>				ADDRESS (Street, city or town, state) <u>Hancock, Maryland</u>				DATE SIGNED <u>4/24/57</u>	
PHYSICIAN'S NAME (Type) <u></u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christain</u>		22d. LOCATION (City, town, or county) (State) <u>Artemas Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honored F. Elmer Hancock md</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>DATE 4/74</u>		24b. REGISTRAR'S SIGNATURE <u>Det Veller</u>	

JAVILAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MAY 3 1957

RECEIVED

4521

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Mos		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 345 No Potomac st e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA BELLE COFFMAN		4. DATE OF DEATH Month Day Year April 27 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2 1872
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Martin Bostetter	
14. MOTHER'S MAIDEN NAME Barbara Sprecher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Frances Odendhal 2 Roessner Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) Hypertensive vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 8 mo 4 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown		(County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 57 , to April 27 , 19 57 , that I last saw the deceased alive on April 27 , 19 57 , and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac st. DATE SIGNED ACTUAL SIGNATURE Lloyd A. Hoffman M.D. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/30/57	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Apr. 30. 1957	
24b. REGISTRAR'S SIGNATURE Wash. Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. S.

MAY 2 1957

RECEIVED

ANTHONY J. COLLIER, BOSTON, MASS.

4522

CERTIFICATE OF DEATH

Dr wells

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>137 So Locust St</u>				d. STREET ADDRESS <u>137 So Locust</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK ALVIN COSS</u>				4. DATE OF DEATH Month Day Year <u>April 26 1957 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Express Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Chewsville Wash. Co Md. USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Coss</u>				14. MOTHER'S MAIDEN NAME <u>Rose Arthur</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>714-05-6867</u>		17. INFORMANT <u>Margaret Coss 137 So Locust St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>acute coronary occlusion</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1hr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>-</u>				20g. (County) <u>-</u>		20h. (State) <u>-</u>	
21. I certify that I attended the deceased from <u>October, 19 40</u> , to <u>April 26, 19 57</u> , that I last saw the deceased alive on <u>April 1, 19 57</u> , and that death occurred at <u>11:45 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u> DATE SIGNED <u>4-27-57</u>							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				115 N. Potomac Street			
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Apr 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Thasht Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar's office to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 2 1957	
AGE		SEX	
68		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		PLACE OF DEATH	
Coronary Artery Disease		Home	
TIME OF DEATH		SIGNATURE OF PHYSICIAN	
10:30 AM		[Signature]	
PLACE OF DEATH		SIGNATURE OF REGISTRAR	
Home		[Signature]	
DATE OF DEATH		DATE OF REGISTRATION	
MAY 2 1957		MAY 2 1957	

RECEIVED
MAY 2 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04527

Reg. Dist. No. **302**

4523

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS SOUTH MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HATTIE Middle S. Last CRONISE				4. DATE OF DEATH Month APRIL Day 19 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ESBY CRONISE				14. MOTHER'S MAIDEN NAME ANNIE SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 36 0322		17. INFORMANT LEO CRONISE BOONSBORO WASH.CO.MD. Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Crownary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 10 minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E.W. Dittus				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 23 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul Daniel Hove				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR Apr 24 1957	
						24b. REGISTRAR'S SIGNATURE Wesley Bowers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04528

4572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>			c. LENGTH OF STAY IN 1b <u>36 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Cascade</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1904</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lantz, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawson P. Poole</u>				14. MOTHER'S MAIDEN NAME <u>Annie Florence Ott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John W. Davis</u> Address <u>Cascade, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac failure =</u> <u>444X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1-1 1/2 hrs.</u> <u>2-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>10 April</u> , 19 <u>57</u> , to <u>10 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 April</u> , 19 <u>57</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harry Young, Jr. M.D. Blue Ridge Summit Pa 7-11-57</u>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lantz, Md. R.D. 1 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Gove</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 15 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Hedrick</u>							

RECEIVED

Dr. Binkford

4524

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown. Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital			d. STREET ADDRESS 1742 Gordon Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BLOICE Middle COSMO Last DAVISON			4. DATE OF DEATH Month April Day 25 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1899		9. AGE (In years last birthday) yrs. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director Of Service		10b. KIND OF BUSINESS OR INDUSTRY Greenville Darke Co		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Claude E. Davison		
14. MOTHER'S MAIDEN NAME Emma Medford			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 376-05-8971			17. INFORMANT Corabelle G. Davison Address 1742 Gordon Road		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) cardiac failure					INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 6 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old myocardial infarction					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 13 Mar. 1957 , to 25 April 1957 , that I last saw the deceased alive on 25 April 1957 , and that death occurred at 9:28 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE HAGERSTOWN, MD. DATE SIGNED 26 APRIL 1957					
ACTUAL PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery	
22d. LOCATION (City, town, or county) Greenville Darke Co Ohio		23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR Apr. 30 1957		24b. REGISTRAR'S SIGNATURE Charles Bowers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
OCCUPATION		PROFESSOR		TEACHER		STUDENT		OTHER	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		OTHER	
RELIGION		METHODIST		CATHOLIC		JEW		OTHER	
CAUSE OF DEATH		HEART DISEASE		STROKE		CANCER		OTHER	
PLACE OF DEATH		HOME		HOSPITAL		PRISON		OTHER	
DATE OF DEATH		MAY 2 1968		MAY 3 1968		MAY 4 1968		OTHER	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	

BUREAU V. S.

MAY 2 1968

RECEIVED

4525

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04530

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VELENCIA ANN DICK</u>				4. DATE OF DEATH Month Day Year <u>April 26 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. AGE (In years last birthday) yrs. <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
13. FATHER'S NAME <u>Leon S. Dick</u>				14. MOTHER'S MAIDEN NAME <u>Beverly Ann Renner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Leon S. Renner Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage into supratentorial</u> DUE TO (c) <u>18hr</u> <u>18hr</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4 PM 25 Apr 1957</u> , to <u>10 AM 26 Apr 1957</u> , that I last saw the deceased alive on <u>26 Apr 1957</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2307 Poloma 26 Apr 57</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Rye</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 29, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Staff Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081231XV5

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>Johns Hopkins</i></p>	
<p>5. Date of death: <i>May 1, 1957</i></p>		<p>6. Place of death: <i>Johns Hopkins</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of coroner: <i>John Doe</i></p>		<p>12. Signature of medical examiner: <i>John Doe</i></p>	
<p>13. Signature of funeral director: <i>John Doe</i></p>		<p>14. Signature of undertaker: <i>John Doe</i></p>	
<p>15. Signature of cemetery: <i>John Doe</i></p>		<p>16. Signature of interment: <i>John Doe</i></p>	
<p>17. Signature of burial: <i>John Doe</i></p>		<p>18. Signature of cremation: <i>John Doe</i></p>	
<p>19. Signature of other: <i>John Doe</i></p>		<p>20. Signature of other: <i>John Doe</i></p>	

BUREAU V. S.

MAY 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4573

CERTIFICATE OF DEATH

04531

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAPLEVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAPLEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD.R.2		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First JACOB Middle M. Last EASTERDAY		4. DATE OF DEATH Month APRIL 6 Day 1957 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 25 1878 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHRISTOPHER EASTERDAY		14. MOTHER'S MAIDEN NAME AMANDA HOUP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. EDNA EASTERDAY		Address BOONSBORO WASH.CO .MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac vascular Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease +</u> DUE TO (c) <u>Myocardial failure</u>			INTERVAL BETWEEN ONSET AND DEATH Min. <u>no</u> 3 day.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculosis - 2 weeks</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 6, 1957</u> , to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>11:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis G. Gaff</u>		ADDRESS (Street, city or town, state) <u>119 E Antietam St</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Gaff M.D.</u>		DATE SIGNED <u>9/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 10 1957	22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY	22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>April 9, 1957</u>	
ADDRESS <u>Boonsboro Md</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Park</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		M		35		W		12-1-21		MOBILE, ALABAMA	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
4-4-68		MOBILE, ALABAMA		HEART DISEASE		NATURAL		[Signature]		[Signature]	
13. FULL NAME OF NEXT OF KIN		14. ADDRESS OF NEXT OF KIN		15. CITY AND STATE OF NEXT OF KIN		16. TELEPHONE NUMBER OF NEXT OF KIN		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESS	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
19. FULL NAME OF DECEASED'S MOTHER		20. ADDRESS OF DECEASED'S MOTHER		21. CITY AND STATE OF DECEASED'S MOTHER		22. TELEPHONE NUMBER OF DECEASED'S MOTHER		23. SIGNATURE OF DECEASED'S MOTHER		24. SIGNATURE OF WITNESS	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
25. FULL NAME OF DECEASED'S FATHER		26. ADDRESS OF DECEASED'S FATHER		27. CITY AND STATE OF DECEASED'S FATHER		28. TELEPHONE NUMBER OF DECEASED'S FATHER		29. SIGNATURE OF DECEASED'S FATHER		30. SIGNATURE OF WITNESS	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. S.

APR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04532	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 238 Summit Ave - Hagerstown						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Died enroute to Wash. County Hospital					d. STREET ADDRESS 1 238 Summit Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Henson Easterday					4. DATE OF DEATH Month Day Year April 1 1957						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Charles Henson					14. MOTHER'S MAIDEN NAME Katherine Shinley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT none		Address Mr. Pride Henson Dem # 4 Shaprsburg Md R#1				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver (fatty infiltration)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <u>S. Robert Wells</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					4-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF April 3 1957		22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery			22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Lee Williams, Md</u>					ADDRESS Hagerstown, Md		24a. REC'D BY REGISTRAR Apr. 4. 1957		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>		

MALAYSIAN STATEMENT OF HEALTH - SINGAPORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Address	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Medical History		Social History		Family History	
Signature of Medical Examiner		Signature of Registrar		Signature of Coroner		Signature of Police Officer		Signature of Witness		Signature of Family Member		Signature of Neighbor		Signature of Other	

BUREAU V. 8

APR 8 1957

RECEIVED

4527

CERTIFICATE OF DEATH

Reg. Dist. No.

04533
302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 HAGERSTOWN			
c. LENGTH OF STAY IN 1b 80 YRS.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 S. POTOMAC ST.				d. STREET ADDRESS 109 S. POTOMAC ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HERMAN Middle RANDOLPH Last EAVEY				4. DATE OF DEATH Month APRIL Day 17 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/18/1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DENTIST				10b. KIND OF BUSINESS OR INDUSTRY OWN PRACTICE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY S. EAVEY				14. MOTHER'S MAIDEN NAME SARAH HOFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. HARRY R. EAVEY HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from JAN 1954 , to APRIL 17, 1957 , that I last saw the deceased alive on APRIL 16, 1957 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above. 4/18/57 ADDRESS (Street, city or town, state) 214 N. Potomac St Hagerstown, Md. DATE SIGNED 4/18/57							
ACTUAL SIGNATURE Lloyd A. Hoffman M.D.							
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR 4/20/57	
				24b. REGISTRAR'S SIGNATURE Bessie Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1945		MEMPHIS, TENN		APR 4, 1968		MEMPHIS, TENN		HEART DISEASE	
OCCUPATION		EDUCATION		RELIGION		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
CONTRACTOR		HIGH SCHOOL		METHODIST		NATURAL		100-100000		YES	
PREVIOUS DEATHS		DATE		PLACE		DATE		PLACE		CAUSE	
NONE											
SIGNATURE OF DECEASED		DATE		PLACE		DATE		PLACE		CAUSE	
SIGNATURE OF WITNESSES		DATE		PLACE		DATE		PLACE		CAUSE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		DATE		PLACE		CAUSE	
SIGNATURE OF CORONER		DATE		PLACE		DATE		PLACE		CAUSE	

BUREAU V. 3

APR 28 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 275 5-10-57 et

4528

CERTIFICATE OF DEATH

Reg. Dist. No. 143212

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quincy / Mt. Wolf, Pa. 75X-3</u>	
c. LENGTH OF STAY IN 1b <u>5 weeks</u>		d. STREET ADDRESS <u>E. N. B. / 10000000 / 1 / Home /</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rev. Frank</u> Middle <u>B. Emenheiser</u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Minister</u>	
11. BIRTHPLACE (State or foreign country) <u>Lower Windsor, York, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Emenheiser</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Ruth Spalding, York Haven, York Co, Pa.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostate Hypertrophy</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u> <u>3 Months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>March 21</u> , 19 <u>57</u> , to <u>April 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>57</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>832 Potomac Ave, Hagerstown, Md.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>J. G. Warden</u> M.D. <u>832 Potomac Ave, Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. G. Warden, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>York Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Gure</u>		ADDRESS <u>Waynesboro, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1912		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JUN 10 1957		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8		METHODIST		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JUN 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		JUN 10 1957		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8		METHODIST		MARRIED		MARRIED	

RECEIVED
MAY 2 1957
BUREAU V. 1

James H. Harris

4529

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>BEAUFORT</u> Last <u>FAHRNEY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>	IF UNDER 24 HRS. Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Luther Middlekauff</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. C.T. Hauver</u> Address <u>821 Concord St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of left hip</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>April 29</u> <u>April 25</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Patient fell</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. <u>Apr. 25 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hagerstown, Wash. Md.</u>
21. I certify that I attended the deceased from <u>Apr. 26, 1957</u> , to <u>Apr. 29, 1957</u> , that I last saw the deceased alive on <u>April 29, 1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Dobbie</u>		M.D. <u>115 King Street, Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John J. Dobbie, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 1, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. G. Frost</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 3 1957
BUREAU V. S.

BUREAU V. S.

MAY 3 1957

RECEIVED

4530

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 WKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>26 North Carlisle st</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Walson</u> Last <u>Fletcher</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/25/1880</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>27</u> Hours <u>77</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>			
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lewis Henry Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Martha E. Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>198-0-3826</u>			
17. INFORMANT <u>Mrs. Julia J. Fletcher</u>				Address <u>Shenandoah, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/1/39</u> , 19____, to <u>4/20/57</u> , 19____, that I last saw the deceased alive on <u>4/20/57</u> , 19____, and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. A. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u>			
PHYSICIAN'S NAME (Type) <u>W. A. Brewer, M.D.</u>				DATE SIGNED <u>4/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>Apr. 23/1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Paul H. Roward</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. 2

APR 25 1957

RECEIVED

4531

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04537

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>816 Guilford Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>JANE</u> Middle <u>FORD</u> Last				4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6, 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Juanita Co., Penn.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham H. Warner</u>				14. MOTHER'S MAIDEN NAME <u>Euphemia Dunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. R. L. Evans</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral sclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive arteriosclerosis heart disease.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2 Feb</u> , 1957, to <u>14 Apr</u> , 1957, that I last saw the deceased alive on <u>13 April</u> , 1957, and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.				ADDRESS (Street, city or town, state) <u>HAGERSTOWN, MARYLAND</u>			
DATE SIGNED <u>15 APRIL 57</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>				HAGERSTOWN, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ruyser</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 20, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis A. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar's office for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4532

CERTIFICATE OF DEATH

04538

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>CECILIA</u> <u>GERKINS</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>7</u> <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1908</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10</u> <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Midland, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Rourke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Charles H. Gerkins Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia bronchial</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive heart failure</u> DUE TO (c) <u>24 hrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had ventral hernia 3 April</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 March, 1957</u> , to <u>7 April, 1957</u> , that I last saw the deceased alive on <u>7 April, 1957</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elder Goodland</u> M.D.				ADDRESS (Street, city or town, state) <u>1154 Washington</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Elder Goodland</u>				<u>Hagerstown, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Rieger</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 9, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4533

CERTIFICATE OF DEATH

04539

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 18 POTOMAC STREET			
3. NAME OF DECEASED (Type or print) First EVA Middle EDNA Last GILBERT				4. DATE OF DEATH APRIL 18 1957 19 19			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 26 1882 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MONROE WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED C. HUFFER				14. MOTHER'S MAIDEN NAME SARAH TOMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT D. GARFIELD GILBERT Address BOONSBORO MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from April 1, 1957 , to April 18, 1957 , that I last saw the deceased alive on April 18, 1957 , and that death occurred at Boonsboro , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 4/21/57							
ACTUAL SIGNATURE G. W. Williams M.D.							
PHYSICIAN'S NAME (Type) G. W. Williams							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 22 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro md. ADDRESS _____				24a. REG'D BY REGISTRAR Apr. 24 1957		24b. REGISTRAR'S SIGNATURE Frank Bowers	

BUREAU V. 3

APR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

4534

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE CALVIN GOOD				4. DATE OF DEATH Month Day Year April 20 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20 1875	
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days Hours Min. 8 0 0 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction			
13. FATHER'S NAME Harvey Good				14. MOTHER'S MAIDEN NAME Elizabeth Mowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-09-3242			
17. INFORMANT Mrs. Dora Good				Address Hagerstown Md. RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Ateypical</i> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.0 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Arteriosclerotic Heart Disease, Malignant destruction of C-2 vertebrae</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1 April</i> , 19 <i>57</i> , to <i>April 20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>20 April</i> , 19 <i>57</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>28 W. Potomac Street</i> DATE SIGNED <i>22 April 57</i> ACTUAL SIGNATURE <i>Paul Hark</i> M.D. <i>Williamspoot, Maryland</i> PHYSICIAN'S NAME (Type) <i>PAUL HARK</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 24-57			
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) (State) Hagerstown Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Legg</i>				24a. REC'D BY REGISTRAR <i>Apr. 23, 1957</i>			
24b. REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

APR 25 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4574 CERTIFICATE OF DEATH

04541

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHARLTON				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE				d. STREET ADDRESS NONE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last COURTNEY CYRUS GROSH				4. DATE OF DEATH Month Day Year APRIL 1 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 24, 1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) CLEAR SPRING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GROSH				14. MOTHER'S MAIDEN NAME MARY JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT COURTNEY GROSH JR. CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Endocarditis 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 2, 1957 to April 1, 1957 , that I last saw the deceased alive on Mar 31, 1957 , and that death occurred at 11 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 4/2/57			
PHYSICIAN'S NAME (Type) David R. Brewer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 3, 1957		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE April 4-57	
				24b. REGISTRAR'S SIGNATURE Joseph W. Murray			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>	
<p>3. AGE _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. OCCUPATION _____</p>	
<p>7. MARITAL STATUS _____</p>		<p>8. CAUSE OF DEATH _____</p>	
<p>9. DATE OF DEATH _____</p>		<p>10. TIME OF DEATH _____</p>	
<p>11. PLACE OF DEATH _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>	
<p>15. SIGNATURE OF WITNESS _____</p>		<p>16. SIGNATURE OF DECEASED _____</p>	
<p>17. SIGNATURE OF WITNESS _____</p>		<p>18. SIGNATURE OF DECEASED _____</p>	
<p>19. SIGNATURE OF WITNESS _____</p>		<p>20. SIGNATURE OF DECEASED _____</p>	
<p>21. SIGNATURE OF WITNESS _____</p>		<p>22. SIGNATURE OF DECEASED _____</p>	
<p>23. SIGNATURE OF WITNESS _____</p>		<p>24. SIGNATURE OF DECEASED _____</p>	
<p>25. SIGNATURE OF WITNESS _____</p>		<p>26. SIGNATURE OF DECEASED _____</p>	
<p>27. SIGNATURE OF WITNESS _____</p>		<p>28. SIGNATURE OF DECEASED _____</p>	
<p>29. SIGNATURE OF WITNESS _____</p>		<p>30. SIGNATURE OF DECEASED _____</p>	
<p>31. SIGNATURE OF WITNESS _____</p>		<p>32. SIGNATURE OF DECEASED _____</p>	
<p>33. SIGNATURE OF WITNESS _____</p>		<p>34. SIGNATURE OF DECEASED _____</p>	
<p>35. SIGNATURE OF WITNESS _____</p>		<p>36. SIGNATURE OF DECEASED _____</p>	
<p>37. SIGNATURE OF WITNESS _____</p>		<p>38. SIGNATURE OF DECEASED _____</p>	
<p>39. SIGNATURE OF WITNESS _____</p>		<p>40. SIGNATURE OF DECEASED _____</p>	
<p>41. SIGNATURE OF WITNESS _____</p>		<p>42. SIGNATURE OF DECEASED _____</p>	
<p>43. SIGNATURE OF WITNESS _____</p>		<p>44. SIGNATURE OF DECEASED _____</p>	
<p>45. SIGNATURE OF WITNESS _____</p>		<p>46. SIGNATURE OF DECEASED _____</p>	
<p>47. SIGNATURE OF WITNESS _____</p>		<p>48. SIGNATURE OF DECEASED _____</p>	
<p>49. SIGNATURE OF WITNESS _____</p>		<p>50. SIGNATURE OF DECEASED _____</p>	
<p>51. SIGNATURE OF WITNESS _____</p>		<p>52. SIGNATURE OF DECEASED _____</p>	
<p>53. SIGNATURE OF WITNESS _____</p>		<p>54. SIGNATURE OF DECEASED _____</p>	
<p>55. SIGNATURE OF WITNESS _____</p>		<p>56. SIGNATURE OF DECEASED _____</p>	
<p>57. SIGNATURE OF WITNESS _____</p>		<p>58. SIGNATURE OF DECEASED _____</p>	
<p>59. SIGNATURE OF WITNESS _____</p>		<p>60. SIGNATURE OF DECEASED _____</p>	
<p>61. SIGNATURE OF WITNESS _____</p>		<p>62. SIGNATURE OF DECEASED _____</p>	
<p>63. SIGNATURE OF WITNESS _____</p>		<p>64. SIGNATURE OF DECEASED _____</p>	
<p>65. SIGNATURE OF WITNESS _____</p>		<p>66. SIGNATURE OF DECEASED _____</p>	
<p>67. SIGNATURE OF WITNESS _____</p>		<p>68. SIGNATURE OF DECEASED _____</p>	
<p>69. SIGNATURE OF WITNESS _____</p>		<p>70. SIGNATURE OF DECEASED _____</p>	
<p>71. SIGNATURE OF WITNESS _____</p>		<p>72. SIGNATURE OF DECEASED _____</p>	
<p>73. SIGNATURE OF WITNESS _____</p>		<p>74. SIGNATURE OF DECEASED _____</p>	
<p>75. SIGNATURE OF WITNESS _____</p>		<p>76. SIGNATURE OF DECEASED _____</p>	
<p>77. SIGNATURE OF WITNESS _____</p>		<p>78. SIGNATURE OF DECEASED _____</p>	
<p>79. SIGNATURE OF WITNESS _____</p>		<p>80. SIGNATURE OF DECEASED _____</p>	
<p>81. SIGNATURE OF WITNESS _____</p>		<p>82. SIGNATURE OF DECEASED _____</p>	
<p>83. SIGNATURE OF WITNESS _____</p>		<p>84. SIGNATURE OF DECEASED _____</p>	
<p>85. SIGNATURE OF WITNESS _____</p>		<p>86. SIGNATURE OF DECEASED _____</p>	
<p>87. SIGNATURE OF WITNESS _____</p>		<p>88. SIGNATURE OF DECEASED _____</p>	
<p>89. SIGNATURE OF WITNESS _____</p>		<p>90. SIGNATURE OF DECEASED _____</p>	
<p>91. SIGNATURE OF WITNESS _____</p>		<p>92. SIGNATURE OF DECEASED _____</p>	
<p>93. SIGNATURE OF WITNESS _____</p>		<p>94. SIGNATURE OF DECEASED _____</p>	
<p>95. SIGNATURE OF WITNESS _____</p>		<p>96. SIGNATURE OF DECEASED _____</p>	
<p>97. SIGNATURE OF WITNESS _____</p>		<p>98. SIGNATURE OF DECEASED _____</p>	
<p>99. SIGNATURE OF WITNESS _____</p>		<p>100. SIGNATURE OF DECEASED _____</p>	

BUREAU V. S.

APR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4535

CERTIFICATE OF DEATH

Reg. Dist. No.

04542

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JAMSVILLE 11x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HARVEY GRUBBS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 13 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1863</u>	
9. AGE (In years last birthday) yrs. <u>93</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>BUSHROD W. GRUBBS</u>			
14. MOTHER'S MAIDEN NAME <u>MARY GORE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>L</u>			
16. SOCIAL SECURITY NO. <u>L</u>				17. INFORMANT <u>EMORY GRUBBS (SON) JAMSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent prostate & hemorrhoid operation; pneumonia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5 April 1957</u> , to <u>13 April 1957</u> , that I last saw the deceased alive on <u>12 April 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard F. Binford</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown MD</u>			
DATE SIGNED <u>13 April 1957</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD F. BINFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KEMPTOWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEMPTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Tolson</u>				ADDRESS <u>New Market VA</u>			
24a. REC'D BY REGISTRAR <u>Chas. A. Brown</u>				24b. REGISTRAR'S SIGNATURE <u>Chas. A. Brown</u>			
DATE <u>APR 22 1957</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. ETHNIC ORIGIN</p> <p>13. SOCIAL CLASS</p> <p>14. INCOME</p> <p>15. HEALTH STATUS</p> <p>16. PREVIOUS ILLNESS</p> <p>17. CAUSE OF DEATH</p> <p>18. MANNER OF DEATH</p> <p>19. PLACE OF DEATH</p> <p>20. TIME OF DEATH</p> <p>21. SIGNATURE OF DECEASED</p> <p>22. SIGNATURE OF WITNESSES</p> <p>23. SIGNATURE OF PHYSICIAN</p> <p>24. SIGNATURE OF CORONER</p> <p>25. SIGNATURE OF JUDGE</p> <p>26. SIGNATURE OF CLERK</p> <p>27. SIGNATURE OF REGISTRAR</p> <p>28. SIGNATURE OF OFFICIAL</p> <p>29. SIGNATURE OF OFFICIAL</p> <p>30. SIGNATURE OF OFFICIAL</p>	
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BUREAU V. 2

APR 22 1957

RECEIVED

04543

CERTIFICATE OF DEATH

Reg. Dist. No.

302

4536

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2417 PENNA AVE, HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 MO.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY HANNAH HAMILTON				4. DATE OF DEATH Month Day Year APRIL 15, 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6, 1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS JONES				14. MOTHER'S MAIDEN NAME ELIZABETH SAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WALTER M. HAMILTON Address ROBINSON ICE & COLD STG., WINCHESTER, VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the uterus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25, 1957 , to April 15, 1957 , that I last saw the deceased alive on April 15, 1957 , at 2:10 PM , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paul F. Webster M.D.				242 East Baltimore Street			
PHYSICIAN'S NAME (Type) Paul F. Webster, M.D.				Greencastle, Pennsylvania			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY HUDSON'S CROSS ROADS		22d. LOCATION (City, town, or county) (State) SHEMADOAH CO., VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Lauren P. Jones				ADDRESS Winchester, Va		24a. REC'D BY REGISTRAR APR 24 1957	
				24b. REGISTRAR'S SIGNATURE Chas. H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1891		BALTIMORE, MD	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		APR 10 1957		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HEART DISEASE		NATURAL		LABORER	
TIME OF DEATH		PLACE OF INTERMENT		NAME OF CEMETERY	
4:30 PM		BALTIMORE, MD		GREENWICH CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE	
J. H. HARRIS		J. H. HARRIS		APR 10 1957	

BUREAU V. B.

APR 24 1957

RECEIVED

James H. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4575

CERTIFICATE OF DEATH

04544

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro			c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 N. Main St				d. STREET ADDRESS 312 N. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Irvin Ira Harbaugh				4. DATE OF DEATH Month Day Year April 30 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Calvin Harbaugh				14. MOTHER'S MAIDEN NAME Catherine McClain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no war		16. SOCIAL SECURITY NO. 219-12-0513		17. INFORMANT Address Mrs. Ralph Hutzel Boonsboro Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Generalized Arteriosclerosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with cerebral thrombosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 45 , to 30 apr , 19 57 , that I last saw the deceased alive on 28 apr , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				M.D. 230 N Potomac		DATE SIGNED 1 May 57	
PHYSICIAN'S NAME (Type) F. F. Lusby				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE May 4 57	
				24b. REGISTRAR'S SIGNATURE John H. Baird Jr			

• *Journal of the American Statistical Association*, 78, 518

511

Dr. J. O. Schreber

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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BUREAU

MAY 7 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Dr Wells 04545
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 4537 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE <u>New York</u> COUNTY <u>Kings</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 9 69X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>547 79th St</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>FLORENCE</u> Last <u>HENRICKSEN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20 1902</u>	
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>No Record</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Unable to Locate Christopher H. henricksen</u> Address <u>547 79th St Brooklyn N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO <u>Closed fracture lt forearm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple lacerations of both thighs</u> DUE TO <u>Contusions to body - Hemorrhage and shock</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in automobile that hit a tractor trailer</u> 20c. TIME OF INJURY Month, Day, Year <u>6:35 a.m. Apr. 26 1957</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> 20f. (City or town) (County) (State) <u>Rural Hagerstown Wash Md</u> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-27-57</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/30/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Green-Wood Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Brooklyn Kings Co New York</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u> 24a. REC'D BY REGISTRAR <u>Apr. 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, and location.

BUREAU V. 3.

MAY 2 1957

RECEIVED

CERTIFICATE OF DEATH

Dr. Harshman
Reg. Dist. No. 302

4538

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4</u> Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Josephine</u> Last <u>Hollinger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5/1869</u>
9. AGE (In years last birthday) <u>87</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Cearsfoss, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Spiokler</u>		14. MOTHER'S MAIDEN NAME <u>Kathrine Gabriel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Danial Hollinger</u>		Address <u>Cearsfoss Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Arteriosclerosis - Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10/4/57 - Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 31, 1957</u> to <u>April 4, 1957</u> , that I last saw the deceased alive on <u>April 4, 1957</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 159 W. Washington St., Hagerstown, Md. 4/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cearsfoss, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	24a. REC'D BY REGISTRAR <u>Phas. Bowers</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4576

CERTIFICATE OF DEATH

Reg. Dist. No.

04547
3027

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Beaver Creek</u>		c. LENGTH OF STAY IN 1b <u>1 yr 6 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural # 1 Beaver Creek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R # 1 - Hagerstown</u>				d. STREET ADDRESS <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>McMahon</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1871</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Jane Daley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Ethel Snyder-(Niece)-</u> Address <u>Beaver Creek, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X</u> DUE TO <u>Adenocarcinoma of cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>none</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 12 <u> </u> , and that death occurred at <u>6:00AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. <u> </u>		ADDRESS (Street, city or town, state) <u>115 N. Potomac Street</u>		DATE SIGNED <u>4-13-57</u>	
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gruid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment</u>		ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 16, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Robert Powers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04548

4539

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON County Hospital</u>				d. STREET ADDRESS <u>1 Boonsboro Md. R.2.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOROTHY ELIZABETH HUTZELL</u>			4. DATE OF DEATH <u>APRIL - 5 - 1957</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 23-1933-23-3-12</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		9. AGE (In years last birthday) <u>23-3-12</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. Co. MD.</u>	
13. FATHER'S NAME <u>ADAM GREEN</u>				14. MOTHER'S MAIDEN NAME <u>SOUDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>217-32-7329</u>		17. INFORMANT <u>WILLIAM M. HUTZELL</u> Address <u>Boonsboro MD. R.2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 days</u> <u>1 year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4/1/57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dwarfism with acute deformity of the thoracic cage</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>She had a ceserean on 3/6/57 for full term baby.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/1/57</u> , 19 <u>57</u> , to <u>4/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/4/57</u> , 19 <u>57</u> , and that death occurred at <u>9:15 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Shealy</u> M.D.				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>4/6/57</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>Boonsboro Md.</u>				24a. REC'D BY REGISTRAR <u>Apr. 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shash Bowerd</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. S.

APR 15 1957

RECEIVED

4540

CERTIFICATE OF DEATH

Dr. Novenstein

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>One week</u>				d. STREET ADDRESS <u>435 Virginia Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cty. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Abraham</u> <u>Jacobson</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>6</u> <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Hirsh Jacobson</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Jacobson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>215-18-1586</u>				17. INFORMANT Address <u>Herbert Jacobson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) _____				435 Virginia Ave.		INTERVAL BETWEEN ONSET AND DEATH <u>March 24-1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27, 1957</u> , to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 5, 1957</u> , and that death occurred at <u>1:07 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				ADDRESS (Street, city or town, state) <u>Falls Church, Fairfax Ct. Va.</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>				DATE SIGNED <u>4-6-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Fairfax Ct. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Apr. 8, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bower</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
LAST NAME FIRST MIDDLE		MONTH DAY YEAR	
AGE		SEX	
MARITAL STATUS		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. S.

APR 11 1957

RECEIVED

4577

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 1 yr 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
				d. STREET ADDRESS 2102 Lexington Ave.,		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Josephine Last Keller				4. DATE OF DEATH Month 4 Day 28 Year 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Middletown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Nikirk				14. MOTHER'S MAIDEN NAME Mary M. Bechtol			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Paul Keller Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 days DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 26 April , 19 57 , to 28 April , 19 57 , that I last saw the deceased alive on 27 April , 19 57 , and that death occurred at 11:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Haak				ADDRESS (Street, city or town, state) 28 W. Falmouth St. Williamsport, Md.			
PHYSICIAN'S NAME (Type) Paul Haak, M.D.				DATE SIGNED 30 April 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR May 2-1957	
				24b. REGISTRAR'S SIGNATURE E Lee McElroy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED Williamson, George		DATE OF DEATH May 4, 1957	
PLACE OF DEATH Home		AGE 71	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION None		RELIGION None	
BIRTH May 4, 1886		PLACE OF BIRTH Maryland	
FATHER George Williamson		MOTHER Mary M. Williamson	
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. [Signature]		SIGNATURE OF REGISTRAR [Signature]	

RECEIVED
MAY 6 1957
BUREAU V. 1

4541

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 East Washington St				d. STREET ADDRESS 49 East Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE		First Middle Last ----- LAMAR		4. DATE OF DEATH April 22 1957		Month Day Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md. Lappans Cross Roads		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marene LaMar				14. MOTHER'S MAIDEN NAME Anne Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Beda LaMar 49 E. Washington St Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertension Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 5 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-7- , 19 55 , to 4-22- , 19 57 , that I last saw the deceased alive on 4-10-57 , 19 57 , and that death occurred at 4 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr E W Ditto Jr		M.D.		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 4-23-57	
PHYSICIAN'S NAME (Type) Dr E W Ditto Jr				ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 4-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR Apr 25 1957		24b. REGISTRAR'S SIGNATURE Chas H Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX Male		AGE 35		DATE OF BIRTH JAN 5 1928	
PLACE OF BIRTH MOBILE, ALABAMA		MARRIAGE None		OCCUPATION None		EDUCATION None	
DATE OF DEATH APR 4 1968		TIME OF DEATH 10:00 AM		PLACE OF DEATH MEMPHIS, TENNESSEE		CAUSE OF DEATH SHOOTING	
MANNER OF DEATH Suicide		DISEASE OR INJURY None		TREATMENT None		POST-MORTEM None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
DATE OF SIGNATURE None		TIME OF SIGNATURE None		PLACE OF SIGNATURE None		CAUSE OF SIGNATURE None	
NAME OF PHYSICIAN None		NAME OF CORONER None		NAME OF WITNESS None		NAME OF DECEASED None	
ADDRESS OF PHYSICIAN None		ADDRESS OF CORONER None		ADDRESS OF WITNESS None		ADDRESS OF DECEASED None	
CITY OF PHYSICIAN None		CITY OF CORONER None		CITY OF WITNESS None		CITY OF DECEASED None	
STATE OF PHYSICIAN None		STATE OF CORONER None		STATE OF WITNESS None		STATE OF DECEASED None	
COUNTRY OF PHYSICIAN None		COUNTRY OF CORONER None		COUNTRY OF WITNESS None		COUNTRY OF DECEASED None	
NAME OF DECEASED None		NAME OF CORONER None		NAME OF WITNESS None		NAME OF PHYSICIAN None	
ADDRESS OF DECEASED None		ADDRESS OF CORONER None		ADDRESS OF WITNESS None		ADDRESS OF PHYSICIAN None	
CITY OF DECEASED None		CITY OF CORONER None		CITY OF WITNESS None		CITY OF PHYSICIAN None	
STATE OF DECEASED None		STATE OF CORONER None		STATE OF WITNESS None		STATE OF PHYSICIAN None	
COUNTRY OF DECEASED None		COUNTRY OF CORONER None		COUNTRY OF WITNESS None		COUNTRY OF PHYSICIAN None	

BUREAU V. 1

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6214 5-(-50 et

4578

CERTIFICATE OF DEATH

Dr Conrad 4552
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> City <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breathesville</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Md State Reformatory for Males</u>				d. STREET ADDRESS <u>2228 W. North Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>LANCASTER</u> Last <u>LANCASTER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 7 1921</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roland Lancaster Sr</u>				14. MOTHER'S MAIDEN NAME <u>Leona Lancaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-2 577-22-9385</u>		17. INFORMANT Address <u>Mrs Leona Lancaster 3251 W. Mount Ave Baltimore Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X Pulmonary Tuberculosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Apr 23</u> , 19 <u>57</u> , to <u>Apr 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 26</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>137 W. Washington</u> DATE SIGNED <u>4-26-57</u>							
ACTUAL SIGNATURE <u>Robert P. Conrad</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u> <u>Hagerstown, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>APR 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowyer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 31

APR 29 1957

RECEIVED

Andrew A. Gollan, Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4579

CERTIFICATE OF DEATH

Reg. Dist. No.

04553
3833

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u> <u>X</u>	
c. LENGTH OF STAY IN 1b <u>40 Y EARS</u>		d. STREET ADDRESS <u>CLEAR SPRING RT 2</u> <u>/</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLEAR SPRING RT 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>MAY</u> Last <u>LEASURE</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 19, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK L. BLOYER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE WINTERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. GEORGE LEASURE</u>		Address <u>CLEAR SPRING RT 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26, 1957</u> , to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 28, 1957</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/29/57</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 1, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BLAIRS VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clear Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH	
13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. PLACE OF INTERMENT		18. NAME OF FUNERAL HOME	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CLERIC		21. SIGNATURE OF WITNESS		22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF BURIAL OFFICIAL	

BUREAU V. S.

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04554

4542 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>18 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 N. MARTIN ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>LEIGH</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>CEMENT FINISHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLDG. CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES K. LEIGH</u>		14. MOTHER'S MAIDEN NAME <u>CORA THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-7462</u>	
17. INFORMANT <u>MRS. MARY LEIGH</u>		Address <u>CLEAR SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 14, 1957</u> , to <u>April 3, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>3:08 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		DATE SIGNED <u>4/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS <u>Clear Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>David R. Brewer</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

APR 8 1957

RECEIVED

4543

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland			
c. LENGTH OF STAY IN 1b 17 yrs.				d. STREET ADDRESS 124 Ruby Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 124 Ruby Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert (ne) Lockley				4. DATE OF DEATH Month 4 Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Sand blast mill		11. BIRTHPLACE (State or foreign country) Boyce Va.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME George Lockley				14. MOTHER'S MAIDEN NAME Mary Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-14-3597			
17. INFORMANT Lucy Lockley				Address 124 Ruby Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Jan 9 , 19 57 , to April 24 , 19 57 , that I last saw the deceased alive on April 3 , 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirshman M.D.				ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown Md. DATE SIGNED 4/24/57			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-57		22c. NAME OF CEMETERY OR CREMATORY Millwood Chapel Cemetery Millwood Va.		22d. LOCATION (City, town, or county) (State) Millwood Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR 4/28/57	
				24b. REGISTRAR'S SIGNATURE Blair H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 30 1957

RECEIVED

4580 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cove Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCY</u> <u>MAY</u> <u>LONG</u>				4. DATE OF DEATH Month Day Year <u>April 15 1957</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hart</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Rosie Doyle Hagerstown Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>57</u> , to <u>April 15</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>April 14</u> , 19 <u>57</u> , and that death occurred at <u>191</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/15/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Furn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Phil 17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Joseph W. M...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Charles H. Dwyer</i>		2. SEX <i>Male</i>	
3. AGE <i>75</i>		4. DATE OF BIRTH <i>1882</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>None</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1910</i>	
9. NAME OF SPOUSE <i>Elizabeth Dwyer</i>		10. DATE OF DEATH <i>1957</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>David B. Dwyer</i>	
15. SIGNATURE OF WITNESS <i>Elizabeth Dwyer</i>		16. SIGNATURE OF REGISTRAR <i>David B. Dwyer</i>	

BUREAU V. S.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4544

CERTIFICATE OF DEATH

Reg. Dist. No.

04558
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 110 South Locust St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle VIRGINIA Last LUCE		4. DATE OF DEATH Month April Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Jamestown, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Moses Starkey		14. MOTHER'S MAIDEN NAME Katherine O'Ferrall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. Starkey		Address 1028 Columbia Rd. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1957 to April 17, 1957 that I last saw the deceased alive on April 15, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Apr 16/57 ACTUAL SIGNATURE J.H. Beachley M.D. PHYSICIAN'S NAME (Type) J.H. Beachley M.D. 221 W. Washington St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Berryville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Enders Funeral Home Reet Haven Funeral Chapel, Inc. Hagerstown, Md. Wm. C. Hunt & P. Co.		24a. REC'D BY REGISTRAR Apr 16, 1957 24b. REGISTRAR'S SIGNATURE Chas H. Powers	

BUREAU V. S.

APR 18 1957

RECEIVED

4545 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hancock Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Hancock Maryland.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Roy Middle Lee Last Lynch				4. DATE OF DEATH Month 4 Day 11 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.3.1898	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months 3 Days 8	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Liquor Store				10b. KIND OF BUSINESS OR INDUSTRY Retail Liquor St.		11. BIRTHPLACE (State or foreign country) Fulton County Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Paul Lynch				14. MOTHER'S MAIDEN NAME Martha Bridges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-8825		17. INFORMANT Mrs Margaret Lynch Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 466X DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of femoral vein (c) 				INTERVAL BETWEEN ONSET AND DEATH 1 Day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 10, 1957 to April 11, 1957 that I last saw the deceased alive on April 11, 1957 , and that death occurred at 6 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED APR 11 1957			
ACTUAL SIGNATURE J. H. Teachley M.D.				PHYSICIAN'S NAME (Type) J. H. Teachley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4.14.57		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Honour & Stone Hancock Md				24a. REC'D BY REGISTRAR Apr 16 1957		24b. REGISTRAR'S SIGNATURE Chas H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

APR 18 1957

RECEIVED

Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG214 4-23-57 et

4546

CERTIFICATE OF DEATH

Reg. Dist. No.

04560
30260

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>673 Pennsylvania Av.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Selena</u>		First <u>Mattie</u>		Middle <u>Millard</u>		Last	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1957</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		B. DATE OF BIRTH <u>Sept 1 1881</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Falls Church, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>arteriosclerosis general</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>1 hr.</u> <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 5, 1956</u> to <u>April 11, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D.				ADDRESS (Street, city, town, state) <u>159 W. Washington St. Hagerstown Md</u> DATE SIGNED <u>4/12/57</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr. Hagerstown Md</u>				24a. REC'D BY REGISTRAR DATE <u>Apr 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Z. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Charles H. ...</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>April 15, 1957</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>	
15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF DECEASED <i>[Signature]</i>	
17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>	
21. SIGNATURE OF DECEASED <i>[Signature]</i>		22. SIGNATURE OF DECEASED <i>[Signature]</i>	
23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>	
27. SIGNATURE OF DECEASED <i>[Signature]</i>		28. SIGNATURE OF DECEASED <i>[Signature]</i>	
29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>	
33. SIGNATURE OF DECEASED <i>[Signature]</i>		34. SIGNATURE OF DECEASED <i>[Signature]</i>	
35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>	
39. SIGNATURE OF DECEASED <i>[Signature]</i>		40. SIGNATURE OF DECEASED <i>[Signature]</i>	
41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>	
45. SIGNATURE OF DECEASED <i>[Signature]</i>		46. SIGNATURE OF DECEASED <i>[Signature]</i>	
47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>	
51. SIGNATURE OF DECEASED <i>[Signature]</i>		52. SIGNATURE OF DECEASED <i>[Signature]</i>	
53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>	
57. SIGNATURE OF DECEASED <i>[Signature]</i>		58. SIGNATURE OF DECEASED <i>[Signature]</i>	
59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>	
63. SIGNATURE OF DECEASED <i>[Signature]</i>		64. SIGNATURE OF DECEASED <i>[Signature]</i>	
65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>	
69. SIGNATURE OF DECEASED <i>[Signature]</i>		70. SIGNATURE OF DECEASED <i>[Signature]</i>	
71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>	
75. SIGNATURE OF DECEASED <i>[Signature]</i>		76. SIGNATURE OF DECEASED <i>[Signature]</i>	
77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>	
81. SIGNATURE OF DECEASED <i>[Signature]</i>		82. SIGNATURE OF DECEASED <i>[Signature]</i>	
83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>	
87. SIGNATURE OF DECEASED <i>[Signature]</i>		88. SIGNATURE OF DECEASED <i>[Signature]</i>	
89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>	
93. SIGNATURE OF DECEASED <i>[Signature]</i>		94. SIGNATURE OF DECEASED <i>[Signature]</i>	
95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>	
99. SIGNATURE OF DECEASED <i>[Signature]</i>		100. SIGNATURE OF DECEASED <i>[Signature]</i>	

RECEIVED
APR 16 1957
BUREAU V. 3

4581

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAPLAND RURAL</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GAPLAND MD.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>VIRGINIA</u> Last <u>MULLENDORE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 11 1889</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SAMPLES MANOR WASH.CO MD. U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. MOATS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE CLINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EARL D. MULLENDORE</u> Address <u>GAPLAND MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>Arteriosclerotic hypertensive C. V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with mitral stenosis.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 Yr.</u> minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Feb. 22</u> , 19 <u>56</u> to <u>April 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>57</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>4/10/57</u>							
ACTUAL SIGNATURE <u>Walter H. Shealy</u>				M.D. <u>Sharpsburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 13 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROWNSVILLE WASH.CO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home Boonsboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Apr 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Katherine Degenhart</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4547

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 144 GREENBERRY RD.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last RONALD GENE MYERS				4. DATE OF DEATH Month Day Year APRIL 15 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/1957	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min. 8		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GUY W. MYERS				14. MOTHER'S MAIDEN NAME HELEN VA. McCAULEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. GUY W. MYERS HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEART FAILURE DUE TO (c) ADRENAL CORTICAL ATROPHY INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 HRS 6 WKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPER TROPHIC PYLORIC STENOSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR. 5 , 19 57 , to APR. 15 , 19 57 , that I last saw the deceased alive on APR. 15 , 19 57 , and that death occurred at 8 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. Washington St. Hagerstown Md. DATE SIGNED 4/16/57							
ACTUAL SIGNATURE Elaine K. Donnellan M.D.				PHYSICIAN'S NAME (Type) DR. FLAINE K. DONNELLAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/17/57		22c. NAME OF CEMETERY OR CREMATORY BROADFORDING CHURCH OF BRETHREN		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr. 18, 1957			
24b. REGISTRAR'S SIGNATURE Frank H. Bowers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081343XV4

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04563
307

4582

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROHRERSVILLE		c. LENGTH OF STAY IN 1b 45 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 ROHRERSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SCHOOL ROAD				d. STREET ADDRESS SCHOOL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle V. Last NICHOLS				4. DATE OF DEATH Month APRIL Day 28 Year 1957			
5. SEX male	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 7 1872		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE OF B.&O.R.R.CO.		10b. KIND OF BUSINESS OR INDUSTRY SAMPLES MANOR WASH.CO.MD.U.S.A.		11. BIRTHPLACE (State or foreign country) SAMPLES MANOR WASH.CO.MD.U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMANUEL NICHOLS				14. MOTHER'S MAIDEN NAME MAHALA BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS ROSE E. NICHOLS ROHRERSVILLE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic myocardial heart disease 422.1 DUE TO myocardial heart failure grade IV Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, .M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 1 1957		22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROHRERSVILLE WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home, Baltimore Md.				24a. REC'D BY REGISTRAR DATE Apr 30 1957		24b. REGISTRAR'S SIGNATURE Mrs Katherine Aquilino	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4553

NAME OF DECEASED
STATE
COUNTY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

BUREAU V. 3

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04564

Reg. Dist. No. 302

4548

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 16 South Vermont Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ray Middle Reardon Last Obitts				4. DATE OF DEATH Month April Day 22 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1920		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 4 Days 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Williamsport, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Obitts				14. MOTHER'S MAIDEN NAME Prudence Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 213-18-9642		17. INFORMANT Mrs. Naomi McCardell Williamsport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 539.1 DUE TO Exophthalmos - Gastroenteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) not known DUE TO (c) not known						INTERVAL BETWEEN ONSET AND DEATH not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) not known							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE A. E. W. Dittus				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) A. E. W. Dittus				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 25, '57		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clifford L. Legg Williamsport, Md.				24a. REC'D BY REGISTRAR Apr. 24, 1957		24b. REGISTRAR'S SIGNATURE John H. Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04565

4549

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 North Ave.				d. STREET ADDRESS 117 North Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Plummer				4. DATE OF DEATH Month Day Year April 22 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1889	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) action builder		10b. KIND OF BUSINESS OR INDUSTRY organ		11. BIRTHPLACE (State or foreign country) Bridgeport Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Frederick H. Plummer				14. MOTHER'S MAIDEN NAME Fannie V. Craley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-083		17. INFORMANT Address Mrs. Jeannette Plummer Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 7 days 9 yr. Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from October, 1948 , to April 22, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 12 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St., Hagerstown Md. DATE SIGNED 4/23/57							
ACTUAL SIGNATURE B. B. Kniesley M.D. 148 West Washington St., Hagerstown Md.							
PHYSICIAN'S NAME (Type) B. B. Kniesley 148 W. Washington St. Hagerstown Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Apr 25 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Gowers			

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BUREAU V. 3.

1957 60. 80.

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4550

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Poffenbarger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23 1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Ervin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. William Poffenbarger</u>		Address <u>119 McComas St Hagerstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myth known and arterial disease heart</u> <u>260x</u> DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Kimmelstiel-Wilson Syndrome</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>10 yrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20</u> 19 <u>56</u> to <u>April 7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 6</u> 19 <u>57</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip Hershman</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Philip Hershman M. D.</u>		ADDRESS (Street, city or town, state) <u>159 W. Washington St Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leal Williamsport Md</u>		24a. REC'D BY REGISTRAR <u>Apr. 8, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Phyllis Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4220

PLACE OF BIRTH

HUSBAND

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

BUREAU V. 2

APR 11 1957

RECEIVED

4551

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>1 yr 8 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Last				4. DATE OF DEATH Month <u>Apr</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		11. BIRTHPLACE (State or foreign country) <u>JACOBSBURG, PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John REMALEK</u>		14. MOTHER'S MAIDEN NAME <u>LUCY QUEENS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>174-10-6580A</u>		17. INFORMANT <u>MRS. CHARLES SIDERGRIN</u> Address <u>HAGERSTOWN MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with</u> <u>420.0</u> DUE TO <u>congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>53</u> , to <u>April 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 29</u> , 19 <u>57</u> , and that death occurred at <u>4:35 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D. <u>148 West Washington St.</u> <u>4/30/57</u>				PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> <u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BATH PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u> ADDRESS <u>HAGERSTOWN, MD.</u>				24a. REC'D BY REGISTRAR <u>May 7, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04567

4552

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Henry Rowan				4. DATE OF DEATH Month Day Year April 27 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1900		9. AGE (In years Jan birthday) yrs. 56	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service man				10b. KIND OF BUSINESS OR INDUSTRY calculating Mach.		11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME James C. Rowan			
14. MOTHER'S MAIDEN NAME Catherine Morris				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes			
16. SOCIAL SECURITY NO. W. W. II 174-03-2748				17. INFORMANT Address Mrs. Emma Hetzler, Pittsburg, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 GASTRIC ULCER - Hemorrhage DUE TO (b) Partial Gastrectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 days.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 7, 1957 , to April 27, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at 4:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 4/29/57							
ACTUAL SIGNATURE Philip J. Hirshman				M.D. 159 W. Washington St., Hagerstown, Md. 4/29/57			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
cremation		4-30-57		Green Mount Cemetery		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR May 1, 1957		24b. REGISTRAR'S SIGNATURE Charles H. Bowers	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased James C. Brown		Age 3 Years		Sex Male		Race White		Date of Birth April 15, 1900		Place of Birth Baltimore, Md.	
Cause of Death Infantile Parotitis		Duration of Illness 10 Days		Place of Death Home		Date of Death May 5, 1903		Time of Death 10:30 A.M.		Signature of Physician James C. Brown	
Signature of Registrar James C. Brown		Signature of Coroner James C. Brown		Signature of Minister James C. Brown		Signature of Undertaker James C. Brown		Signature of Burial Place James C. Brown		Signature of Cemetery James C. Brown	

BUREAU V. 2

MAY 3 1957

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Name of Deceased James C. Brown		Age 3 Years		Sex Male		Race White		Date of Birth April 15, 1900		Place of Birth Baltimore, Md.	
Cause of Death Infantile Parotitis		Duration of Illness 10 Days		Place of Death Home		Date of Death May 5, 1903		Time of Death 10:30 A.M.		Signature of Physician James C. Brown	
Signature of Registrar James C. Brown		Signature of Coroner James C. Brown		Signature of Minister James C. Brown		Signature of Undertaker James C. Brown		Signature of Burial Place James C. Brown		Signature of Cemetery James C. Brown	

4553

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>JACKSON</u> Last <u>RUSSELL</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 1, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engine Hostler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Russell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Albert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. I 705-10-8590</u>		17. INFORMANT <u>Mrs. Agnes S. Russell Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown, Md</u>				20g. (County) <u>Washington</u>			
20h. (State) <u>Md</u>							
21. I certify that I attended the deceased from <u>Jan 15</u> , 1957, to <u>Apr 11</u> , 1957, that I last saw the deceased alive on <u>4-11</u> , 1957, and that death occurred at <u>4:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert P. Conrad</u>				ADDRESS (Street, city or town, state) <u>137 W Washington</u>			
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				DATE SIGNED <u>4-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ruzer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 15, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12. 2001-12-12

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

04569

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN 1b 6 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1910 Virginia Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula May Santman		4. DATE OF DEATH Month April Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1976
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Germantown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William L. G. Appleby		14. MOTHER'S MAIDEN NAME Augusta Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT W. J. Santman		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - emboli 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured Hip - DUE TO (c) 6 weeks		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.7		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell while standing in middle of floor		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. March 4 1957 - p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) F.K. Home for Aged Boonsboro		20f. (City or town) (County) (State) Washington Md	
21. I certify that I attended the deceased from Feb 2 , 1957, to April 1 , 1957, that I last saw the deceased alive on March 31 , 1957, and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. LeVan M.D.		ADDRESS (Street, city or town, state) Boonsboro, Md.	
DATE SIGNED 4/2/57			
PHYSICIAN'S NAME (Type) Gerald W. LeVan, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE April 6 1957		24b. REGISTRAR'S SIGNATURE John H. Ball	

RECEIVED

APR 8 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04570

4551

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 West Washington Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROY</u> First <u>PORTER</u> Middle <u>SHREINER</u> Last		4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1884</u>
9a. AGE (In years last birthday) <u>72</u> yrs.		9b. IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union Tele.</u>	
11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Shreiner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-7955</u>	
17. INFORMANT <u>Mrs. Sarah E. Shreiner Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> (c) <u>12 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-1-1956</u> , to <u>4-27-1957</u> , that I lost the deceased alive on <u>4-26-1957</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>D. EW. Smith</u> ADDRESS (Street, city or town, State) <u>Hagerstown, Md.</u> DATE SIGNED <u>4/27/57</u> PHYSICIAN'S NAME (Type) <u>D. EW. Smith</u> M.D. <u>Hagerstown, Md.</u> <u>4/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. S. Rouzer</u>		24a. REC'D BY REGISTRAR <u>Apr. 29. 1957</u> <u>W. H. Bowers</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAY 1 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
4555
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG211 4-23-57 et
CERTIFICATE OF DEATH

04571

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Wash. Co. Hagerstown MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hosp.		d. STREET ADDRESS 334 N. Jonathan Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby First Middle Last Smith		4. DATE OF DEATH Month Day Year April 12 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/57
9. AGE (In years lost birthday) yrs. 17		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Shirley Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Shirley Smith 334 N. Jonathan St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO (b) <i>Placental Rupture - 6 mos. lat 1/11/22</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>17 hrs.</i> DUE TO (b) <i>17 hrs.</i> DUE TO (c) <i>17 hrs.</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12, 1957, to April 12, 1957, that I last saw the deceased alive on April 12, 1957, and that death occurred at 7 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Philip J. Hirshman		M.D. Hagerstown, Maryland 4/15/57	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.		24a. REC'D BY REGISTRAR 4/16/57 24b. REGISTRAR'S SIGNATURE	

208/161XVO

CERTIFICATE OF DEATH

RECEIVED
 APR 18 1957
 BUREAU V. S.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		Maryland		Baltimore		Heart Disease		April 15, 1957		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Married		Single		Widowed		Divorced		Last Illness		Duration of Illness		Previous Illnesses		Previous Operations		Previous Injuries		Previous Habits		Previous Occupations	
Teacher		Yes		No		No		No		Chest Pain		3 Weeks		Hypertension		None		None		None		None	
Education		High School		College		University		Postgraduate		Family History		Family History		Family History		Family History		Family History		Family History		Family History	
High School		Yes		No		No		No		Heart Disease		Yes		No		No		No		No		No	
College		Yes		No		No		No		Hypertension		Yes		No		No		No		No		No	
University		Yes		No		No		No		Diabetes		Yes		No		No		No		No		No	
Postgraduate		Yes		No		No		No		Cancer		Yes		No		No		No		No		No	
Family History		Yes		No		No		No		Stroke		Yes		No		No		No		No		No	
Heart Disease		Yes		No		No		No		Kidney Disease		Yes		No		No		No		No		No	
Hypertension		Yes		No		No		No		Lung Disease		Yes		No		No		No		No		No	
Diabetes		Yes		No		No		No		Liver Disease		Yes		No		No		No		No		No	
Cancer		Yes		No		No		No		Blood Disease		Yes		No		No		No		No		No	
Stroke		Yes		No		No		No		Mental Disease		Yes		No		No		No		No		No	
Kidney Disease		Yes		No		No		No		Other		Yes		No		No		No		No		No	
Lung Disease		Yes		No		No		No		Other		Yes		No		No		No		No		No	
Liver Disease		Yes		No		No		No		Other		Yes		No		No		No		No		No	
Blood Disease		Yes		No		No		No		Other		Yes		No		No		No		No		No	
Mental Disease		Yes		No		No		No		Other		Yes		No		No		No		No		No	
Other		Yes		No		No		No		Other		Yes		No		No		No		No		No	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4556

CERTIFICATE OF DEATH

Reg. Dist. No. 04572

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 619 GEORGE ST.	
3. NAME OF DECEASED (Type or print) DEBORAH KAY SMITH		4. DATE OF DEATH Month APRIL Day 22 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZENSHIP OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CARL E. SMITH		14. MOTHER'S MAIDEN NAME HELEN A. FIDDLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HELEN A. SMITH		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Immaturity DUE TO Parturition - 6 Mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parturition - 6 Mos. (c) unknown.			INTERVAL BETWEEN ONSET AND DEATH 6 mo 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-20 , 19 57 , to 4-22 , 19 57 , that I last saw the deceased alive on April 21 , 19 57 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam DATE SIGNED 8/2/57 ACTUAL SIGNATURE Lewis S. Graff M.D. PHYSICIAN'S NAME (Type) LEWIS S GRAFF			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/23/57	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		24a. REC'D BY REGISTRAR Apr. 25, 1957	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

2081273 XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04573

4584

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			c. LENGTH OF STAY IN 1b _____	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bolling Air Force Base 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Richard Middle Eugene Last Smith </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month April Day 20, Year 19 57 </div>			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1934		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY Smithsburg, Md.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Benjamin E. Smith				14. MOTHER'S MAIDEN NAME Florence Irene Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 9-11-52 to 214-30-1898		17. INFORMANT Address Mrs. Florence I. Needy, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture Skull DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ </div>							INTERVAL BETWEEN ONSET AND DEATH instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from speeding auto which struck pole					
20c. TIME OF INJURY Month, Day, Year Hour 6:45 a.m. 4-20 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State R 64 Smithsburg Washington Md		20f. (City or town) (County) (State) Smithsburg Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edw. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Edw. Ditto, Jr., M.D.				DATE SIGNED 4/24/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-23-57		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR DATE APR 25 '57		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BAYLOR 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. BAYLOR		45		M		W		APRIL 18, 1957	
RESIDENCE		CITY		COUNTY		STATE		DECEASED AT HOME	
1000 BAYLOR ST.		BOSTON		SUFFOLK		MASS.		YES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
CLERK		HIGH SCHOOL		MARRIED		CATHOLIC		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		NAME OF SPOUSE		MANNER OF DEATH	
APRIL 18, 1912		BOSTON, MASS.		JULY 1, 1935		JANE BAYLOR		NATURAL	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER		DATE OF REPORT	
APRIL 18, 1957		BOSTON, MASS.		JAMES J. BAYLOR		[Signature]		APRIL 18, 1957	

BUREAU V. 4

PR 25 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04574

4585

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROHRERSVILLE M.R.I				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL JACOB SMITH				4. DATE OF DEATH Month APRIL Day II Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 28 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE				10b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD AIRCRAFT LOCUST GROVE WASH.		11. BIRTHPLACE (State or foreign country) CO. MD. U.S.A.	
13. FATHER'S NAME SAMUEL SMITH				14. MOTHER'S MAIDEN NAME ANNA GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220 09 9131			
17. INFORMANT MRS. MYRTLE SMITH ROHRERSVILLE MD.R.I				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 18, 1957 , to April 11, 1957 , that I last saw the deceased alive on April 10, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) Boonsboro DATE SIGNED 4/13/57			
PHYSICIAN'S NAME (Type) G.W. Helvan				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF APRIL 14 1957				22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY			
22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD.				23. FUNERAL DIRECTOR'S SIGNATURE Boonshus Md.			
24a. REC'D BY REGISTRAR DATE Apr 15-1957				24b. REGISTRAR'S SIGNATURE Wm. Katherine B. Bensch			

BUREAU V. S.

APR 17 1957

RECEIVED

4557

CERTIFICATE OF DEATH

Dr. Ditto Jr.

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1113 Salem Ave			d. STREET ADDRESS 1113 Salem Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) R. E. Spessard			4. DATE OF DEATH Month April Day 25 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1907		9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sand Blast Operator Pangborn		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md		11. BIRTHPLACE (State or foreign country) Wash. Co	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Cleggett Spessard		
14. MOTHER'S MAIDEN NAME Annie Whitmore			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 219-12-0399			17. INFORMANT Mrs Mildred Spessard		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Carcinoma Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) 17 mo (c) 17 mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hagerstown Md.			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 5-1-56 to 4-25-57 , that I last saw the deceased alive on 4-25-57 , and that death occurred at 6:55 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. J. W. Ditto		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) Dr. J. W. Ditto		ADDRESS Hagerstown Md		DATE SIGNED 4/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Md.		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman			23a. ADDRESS Hagerstown, Md.		
23b. REC'D BY REGISTRAR Apr 30, 1957			23c. REGISTRAR'S SIGNATURE Phyllis Bowers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7,8,14:G214 4-30-57

4558

CERTIFICATE OF DEATH

Reg. Dist. No.

04576

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Home				d. STREET ADDRESS 3331 Virginia Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edith Middle Kirl Last Sylvester				4. DATE OF DEATH Month April Day 1 Year 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Edward Perkins				14. MOTHER'S MAIDEN NAME Alice E. Meekin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. --		17. INFORMANT Elmer Sylvester, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arterio Sclerosis DUE TO (c) 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <input type="checkbox"/> p. m. <input type="checkbox"/> 19 <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) APR 1 1957				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from APR 1 1957 to APR 1 1957 , that I last saw the deceased alive on APR 1 1957 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 221 W. Washington St., Hagerstown DATE SIGNED APR 2 1957							
ACTUAL SIGNATURE Jack H. Beachley, M.D.				M.D. 221 W. Washington St., Hagerstown			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-4-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS 4.1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES SYLVESTER		AGE 1 Year		SEX Male		RACE White		EDUCATION None		MARRIAGE None		OCCUPATION None		RESIDENCE 3331 Virginia Ave.		CITY Baltimore City, Md.		STATE Maryland		COUNTY Baltimore	
DATE OF DEATH April 1, 1957		TIME OF DEATH 11:00 AM		PLACE OF DEATH Home		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		DISEASE OR INJURY None		TREATMENT None		POST-MORTEM None		SIGNATURE OF PHYSICIAN James T. McKinnon		SIGNATURE OF DECEASED James T. McKinnon		SIGNATURE OF WITNESS James T. McKinnon	
DATE OF BIRTH April 1, 1956		TIME OF BIRTH 11:00 AM		PLACE OF BIRTH Home		CAUSE OF BIRTH Sudden		MANNER OF BIRTH Natural		DISEASE OR INJURY None		TREATMENT None		POST-MORTEM None		SIGNATURE OF PHYSICIAN James T. McKinnon		SIGNATURE OF DECEASED James T. McKinnon		SIGNATURE OF WITNESS James T. McKinnon	
DATE OF DEATH April 1, 1957		TIME OF DEATH 11:00 AM		PLACE OF DEATH Home		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		DISEASE OR INJURY None		TREATMENT None		POST-MORTEM None		SIGNATURE OF PHYSICIAN James T. McKinnon		SIGNATURE OF DECEASED James T. McKinnon		SIGNATURE OF WITNESS James T. McKinnon	

BUREAU V. S.

APR 8 1957

RECEIVED

4559
CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 East Antietam St,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST BERTIE MAY TAYLOR		4. DATE OF DEATH Month Day Year April 25 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Millstone, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alex Myers		14. MOTHER'S MAIDEN NAME Della Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5278	
17. INFORMANT Mr. J. W. Taylor		Address 4 E. Antietam St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO (b) Arteriosclerosis C-V System DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 months Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intr. Abdominal Cancerous Type Undetermined			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 23, 1949, to April 25, 1957, that I last saw the deceased alive on April 25, 1957, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE L.L. Packer M.D.		ADDRESS (Street, city or town, state) 145 W. Wash St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) L.L. Packer M.D.		DATE SIGNED 145 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Clearspring Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1957

RECEIVED

4560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>9 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>				d. STREET ADDRESS <u>249 So Locust St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>JANE</u> Last <u>TOWSON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feby 9 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dwn Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Foster</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Anna E. Everly 249 So Locust St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid Carcinoma of Bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>				14 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan</u> <u>1957</u> , to <u>4-28</u> <u>1957</u> , that I last saw the deceased alive on <u>4-27-57</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts. Bldg.</u> DATE SIGNED <u>4-29-57</u>							
ACTUAL SIGNATURE <u>W Layman</u> M.D. <u>100 Professional Arts. Bldg.</u>							
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>4/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W Layman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARKLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MAY 2 1957

RECEIVED

4561 CERTIFICATE OF DEATH

Dr. Harrison

04579

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>2 Weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Virginia</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Myers</u>		14. MOTHER'S MAIDEN NAME <u>Bessie V Koontz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Raymont S. Turner</u>		Address <u>225 Mill Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary Cirrhosis</u> DUE TO <u>Biliary Duct Stricture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 4, 1955</u> to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>318 No Potomac St Hagerstown Md</u>	
DATE SIGNED <u> </u>		DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>Dr Paul Harrison</u>		PHYSICIAN'S NAME (Type) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank Bowser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 5 1957

RECEIVED

4562

CERTIFICATE OF DEATH

04580

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 31 Fenton Ave. 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Preston Last Turner		4. DATE OF DEATH Month April Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 1 Days 3 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Byrons Tannery	
11. BIRTHPLACE (State or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Turner		14. MOTHER'S MAIDEN NAME Anna Mary Popp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-01-9881	
17. INFORMANT Mrs. Pearl Turner		Address 31 Fenton Ave. Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic nephrosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction 4 days duration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 4, 19 57, to April 10, 19 57, that I last saw the deceased alive on April 10, 19 57, and that death occurred at 7:05 pm from the causes and on the date stated above.			
ACTUAL SIGNATURE Archie Robert Cohen		DATE SIGNED 4/12/57	
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		ADDRESS (Street, city or town, state) Clear Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 13-57	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	22d. LOCATION (City, town, or county) (State) Williamsport Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf		24a. REC'D BY REGISTRAR 12/1957	
24b. REGISTRAR'S SIGNATURE Blanch H. Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

APR 16 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04582
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL- Pinesburg X 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Washington County Hospital</u>			d. STREET ADDRESS <u>Williamsport, R.F.D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Edwin Wetzel</u>			4. DATE OF DEATH Month Day Year <u>April 26 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1922</u>		9. AGE (In years last birthday) <u>34</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker Fairchild Aircraft Hagerstown, Md.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	IF UNDER 1 YEAR Months Days Mins. <u>34</u> <u>8</u> <u>15</u>
13. FATHER'S NAME <u>Harvey William Wetzel</u>			14. MOTHER'S MAIDEN NAME <u>Audrey Acord</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>718-01-4335</u>		17. INFORMANT <u>Mrs. Mabel Wetzel Williamsport, Md. RFD #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-26-57</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Williamsport, Maryland</u>		22e. REC'D BY REGISTRAR <u>Apr. 29 1957</u>		22f. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lef</u>		ADDRESS <u>Williamsport, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 18

DECEASED

NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

CAUSE OF DEATH

MODE OF DEATH

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SEX

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

RECEIVED
MAY 1 1957
BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4564

CERTIFICATE OF DEATH

04581

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Frank Wiebel, Sr.				4. DATE OF DEATH Month April Day 14 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rural carrier				10b. KIND OF BUSINESS OR INDUSTRY post office Dep.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Augusta Wiebel				14. MOTHER'S MAIDEN NAME Henrietta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I - -		17. INFORMANT Address Mrs. Helen Wiebel, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) general arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 18 , 19 57 , to Apr. 14 , 19 57 , that I last saw the deceased alive on Apr. 14 , 19 57 , and that death occurred at 6 30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto				ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown			
NAME (Type) Edward W. Ditto, III, M.D.				DATE SIGNED 4/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-16-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr 18 1957		24b. REGISTRAR'S SIGNATURE Thas H. Bowers	

CERTIFICATE OF DEATH

DECEASED NAME JAMES M. JONES		SEX Male		AGE 35	
RACE White		BIRTH DATE 1922		PLACE Baltimore, Md.	
OCCUPATION Clerk		RESIDENCE 1234 N. E. St. Baltimore, Md.		COUNTY Baltimore	
CAUSE OF DEATH Myocardial Infarction		DATE OF DEATH April 1, 1957		TIME OF DEATH 10:15 AM	
PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. 2

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04583

4565

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Lagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hosp</u>				d. STREET ADDRESS <u>1938 Pope Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Lynn</u> Last <u>Wingerd</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1957</u>	9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS. Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co. Hosp</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>George Martin Wingerd</u>				14. MOTHER'S MAIDEN NAME <u>Vivian Amelia Spence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>938 Pope Ave. Lag. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>758.6</u> DUE TO <u>Congenital defect</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abuse of spinal column & cranium</u> DUE TO (c) <u>Abuse of spinal column & cranium</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>46 Month</u> INTERVAL BETWEEN ONSET AND DEATH <u>46 Month</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-16-1957</u> to <u>4-16-1957</u> , that I last saw the deceased alive on <u>4-16-1957</u> , and that death occurred at <u>4:41</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. W. Dittus</u> M.D. <u>Dr. E. J. Dittus Jr. Lag. Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>A. E. W. DITTUS Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williams</u> ADDRESS <u>2011 Williamsport, Md</u>				24a. REC'D BY REGISTRAR <u>Apr 19, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

2181316 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4566

CERTIFICATE OF DEATH

04584

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle 75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>123 South Carlisle St</u>	
3. NAME OF DECEASED (Type or print) <u>Phyllis Regina Wingerd</u>		4. DATE OF DEATH <u>April 7, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1929</u> 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Coyl E. Barrick</u>		14. MOTHER'S MAIDEN NAME <u>Erma Swartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unable to obtain</u>	
17. INFORMANT <u>Mr. Richard C. Wingerd, Greencastle Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mos</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericarditis, Pneumonia, Pulm. edema.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 April, 1957</u> to <u>7 April, 1957</u> , that I last saw the deceased alive on <u>7 April, 1957</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		ADDRESS (Street, city or town, state) <u>HAGERSTOWN, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>		DATE SIGNED <u>9 APRIL 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>		ADDRESS <u>Greencastle, Pa</u>	
24a. REC'D BY REGISTRAR <u>Apr 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank Bowers</u>	

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

APR 15 1957

1135 POTOMAC AVENUE HAGERSTOWN, MARYLAND

RICHARD T. BINFORD, M.D.

Yours truly,
Wm. Lloyd Garrison

BUREAU V. S.

RECEIVED